CDI Clinical Scenario 3

CLINICAL DOCUMENTATION IMPROVEMENT:

An Introduction Into The Field of CDI

MARSI

MEDICAL AUDIT RESOURCE SERVICES, INC.

DISCHARGE SUMMARY

DATE OF ADMISSION:

DATE OF DISCHARGE:

ADMITTING PHYSICIAN:

PRIMARY CARE PHYSICIAN:

CONSULTING GASTROENTEROLOGIST:

DISCHARGING PHYSICIAN:

ADMITTING DIAGNOSES:
1. Oropharyngeal dysphagia secondary to recurrent oropharyngeal squamous cell carcinoma.
2. Protein calorie malnutrition secondary to dysphagia.
3. Chronic dysphagia secondary to oropharyngeal cancer.
4. Chronic obstructive pulmonary disease.
5. Microcytic hypochromic anemia.
6. Anorexia and debility with a body mass index of 17.

DISCHARGE DIAGNOSES:
1. Status post PEG tube placement on
2. Oropharyngeal dysphagia secondary to multiple recurrent oropnaryngeal squamous cell carcinoma.
3. Non-oxygen dependent chronic obstructive pulmonary disease.
4. Persistent tobacco abuse.
5. History of heavy alcohol use in the past.
6. Microcytic normocytic anemia, symptoms stable.
7. Hypomagnesemia, corrected.
8. Anorexia and debility.
9. Protein calorie malnutrition with a body mass index of 17.

DISPOSITION: The patient will follow up with Dr. his ENT surgeon. He is scheduled for future oropharyngeal surgery. Follow up with Dr. Vasireddy, primary oncologist.

HISTORY OF PRESENT ILLNESS AND HOSPITAL COURSE: For detailed history of present illness, please see the admitting history and physical and the subsequent consultation notes. In summary, the patient is a pleasant 71-year-old gentleman with a history of recurrent oropharyngeal cancer. Secondary to the oral cancer, he has had dysphagia and has lost a profound weight and currently anorexic with a body mass index of 17. The patient was admitted primarily for dehydration and malnutrition. d was consulted and the patient had a successful PEG tube placement. The patient has been discharged home and will continue to bolus feeding. The patient has been evaluated by the dietitian and we will follow the dietitian's recommendations.

PHYSICAL EXAMINATION: On evaluation today prior to discharge, he is afebrile with stable vitals as follows: Temperature 36.8, pulse 94, respiration 18 and blood pressure 104/65.

CURRENT LABORATORY DATA: Significant for the following: Hematology: WBC 6.0, hemoglobin 11.2, hematocrit 33.2 and platelets 283. Electrolytes: Sodium 140, potassium 3.3, chloride 104, CO2 of 27, BUN 10, creatinine 0.9.

The patient is discharged in stable condition. We will follow with and with as instructed.

HISTORY & PHYSICAL

DATE OF ADMISSION:

ADMITTING SERVICE:

ONCOLOGIST:

PRIMARY ENT:

PRIMARY PULMONOLOGIST:

CHIEF COMPLAINT: Weight loss, lethargy, confusion and oropharyngeal dysphagia.

HISTORY OF PRESENT ILLNESS: is a 71-year-old male, who has been smoking since he was 8 years of age and he continues to smoke. He smokes a pack a day and he lives with his wife.

His history goes back to April 2014 when he had a bronchoscopy with bronchoalveolar lavage for left upper lobe pulmonary density. He has a history of pulmonary histoplasmosis in the past and a history of throat cancer.

On 10/07/2014, he was seen by ENT and had a wide local excision of a 2 cm lesion in the right buccal mucosa. Apparently, he first started to experience in 2010 squamous cell carcinoma of the soft palate. This was treated with chemotherapy and radiation therapy and he was somewhat last to follow up until 2014. He was rereferred to Dr. hematologist/oncologist.

On 12/30/2014, he had an excisional biopsy of a 2 cm ulcerative lesions of the left retromolar trigone by On 03/07/2015, he once again had excisional biopsy of 2.5 cm lesion of the left posterior oral tongue by . On 02/09/2016, he once again saw and had a wide local excision of 5 cm squamous cell carcinoma of the left oral tongue with complex reconstruction.

Unfortunately, this patient has developed multiple oral cavity of squamous cell carcinoma in the past year. He has had four oral cavity cancers in less than 18 months and he continues to abuse tobacco.

He last saw on 02/18/2016 and had some sutures removed after his last excision on 02/19/2016.

At this time, he presents with oropharyngeal dysphagia, decreased p.o. intake, weight loss. He is currently 112 pounds, decreased p.o. intake.

At this time, he wants to be considered for a PEG placement. He has had a PEG placement in the past. , GI was consulted by ED physician and ENT was also consulted.

PAST MEDICAL HISTORY:
1. Multiple squamous cell carcinoma, recurrent, of oral cavity with multiple resections.
2. Chronic obstructive pulmonary disease.
3. Continued tobacco use/abuse.
4. History of pulmonary histoplasmosis, which was treated in the past.

PAST SURGICAL HISTORY:
1. Multiple excisions of squamous cell carcinoma of the oral cavity.
2. PEG tube placement in the past.
3. Inguinal hernia repair.
4. Bilateral cataract surgery.

SOCIAL HISTORY: He is a DNR, lives with his wife and is ambulatory without assistive devices. He smokes a pack a day and has been smoking since he was 8 years of age. He also admits to heavy alcohol use/abuse and stopped drinking 4 to 5 months ago. He has 2 children and is a retired construction worker.

MEDICATIONS: None.

ALLERGIES: No known drug allergies.

FAMILY HISTORY: His mother died at 60 of a myocardial infarction. She had coronary artery disease. His father died at 72 of myocardial infarction. One brother also had throat cancer and died from complications of this.

REVIEW OF SYSTEMS:
GENERAL: Admits to weight loss, fatigue, weakness. Denies any fever, chills or night sweats.
SKIN, HEAD, EYES, EARS, NOSE, SINUSES: Negative.
MOUTH, THROAT and NECK: He admits to hoarseness, sore throat, recurrent oropharyngeal cancer, dysphagia.
RESPIRATORY: Admits to wheezing, emphysema, shortness of breath.
CARDIAC: Negative.
GASTROINTESTINAL: Admits to weight loss. Denies any nausea, vomiting, diarrhea, constipation, hematemesis, hematochezia, abdominal pain, jaundice or hepatitis.
URINARY: Negative.
VASCULAR: Negative.
MUSCULOSKELETAL: Negative.
NEUROLOGIC: Negative.
HEMATOLOGIC: Negative.
ENDOCRINE: Negative.
PSYCHIATRIC: Negative.

PHYSICAL EXAMINATION:
GENERAL: This is a thin elderly Caucasian male. His BMI is 17. He is lying flat in bed in no distress, alert and oriented times 3. He is on room air.
VITAL SIGNS: Temperature 36.4, pulse 89 equal, regular bilaterally, respiratory rate 18, blood pressure 112/64, oxygen saturation 97% on room air.
EYES: Pupils equal, round, reactive to light and accommodation. Extraocular movements intact. No conjunctival injection or lid ptosis.
EARS, NOSE, MOUTH AND THROAT: Edentulous. There is a gangrenous lesion to the left infra lingular region. Normal external inspection of the ears and nose. Normal inspection of the nasal mucosa, septum and turbinates. Hearing seems to be grossly intact. He speaks in a hoarse voice.
NECK: No JVD, tracheal deviation, nuchal rigidity, thyroid masses enlargement or tenderness to palpation.
RESPIRATORY: Diminished breath sounds bilaterally. No rales, rhonchi or wheezes heard. No anterior chest wall tenderness to palpation, increased PA chest diameter.
CARDIOVASCULAR: Regular rate and rhythm. He has a grade II/VI systolic murmur, best heard in the left second intercostal space. No edema or varicosities of the extremities. No carotid artery bruits auscultated. Bilateral dorsal pedal pulses are equal palpable 2+ bilaterally.
GASTROINTESTINAL: Abdomen is soft, nontender to palpation. Bowel sounds are heard equal in all 4 quadrants. No hepatosplenomegaly, masses or hernias palpable.
NEUROLOGIC: Cranial nerves II-XII grossly intact. Normal deep tendon reflexes exam. No pathological reflexes elicited. Sensation to touch intact.
SKIN: No rashes, lesions, ulcers, induration, nodules or tightening.
MUSCULOSKELETAL: Full range of movement in right and left upper and lower extremities without pain, crepitation, contractures, instability. Normal muscle strength and tone without atrophy or abnormal movements.
PSYCHIATRIC: The patient is oriented to time, place and person. Mood and affect appropriate. Recent and remote memory intact. Judgment and insight intact.

LABORATORY DATA: Sodium 137, potassium 4.6, chloride 103, CO2 of 28, BUN 27, creatinine 1.1, GFR greater than 60, glucose 78. White blood cell count 8200, hemoglobin 11.1, hematocrit 34.4, MCV 100.9, platelets 299.

ASSESSMENT AND PLAN:
1. Oropharyngeal dysphagia secondary to recurrent oropharyngeal squamous cell carcinoma. He was first diagnosed with invasive squamous cell carcinoma around 2010. He has had multiple excisions of lesions, most recent one was on 02/09/2016. Pathology report demonstrates invasive squamous cell carcinoma of the left lower tongue. He follows up with ENT. We will get swallow evaluation, dietitian consult. Start Ensure t.i.d. GI was consulted by ED physician for possible PEG placement.
2. Chronic obstructive pulmonary disease. Continue bronchodilator breathing treatments, oxygen support and monitor.
3. Tobacco use/abuse. The patient has been smoking a pack a day since 8 years of age. Counseled on cessation.
4. Heavy alcohol use in the past.
5. Microcytic hypochromic anemia, stable. We will continue to monitor.
6. Anorexia and debility with a BMI of 17 more than likely secondary to #1. We will get dietitian consulted and continue to monitor.
7. Systolic heart murmur. Obtain echocardiogram.
8. Treated in the past for pulmonary histoplasmosis.
9. DO NOT RESUSCITATE/DO NOT INTUBATE.
10. Deep venous thrombosis prophylaxis with sequential compression devices.

CONSULTATION

DATE OF CONSULTATION:

ATTENDING PHYSICIAN:

PATIENT'S LOCATION:

DATE OF CONSULTATION:

REASON FOR CONSULTATION: Dysphagia.

HISTORY OF PRESENT ILLNESS: This 71-year-old patient with history of recurrent oropharyngeal carcinoma, came to the Emergency Room with difficulty in swallowing and patient has not been able to swallow both liquids or solids and has lost a great deal of weight. In the Emergency Room, he was felt to be dehydrated, and on attempts to swallow water were also not successful. The patient was admitted for further workup. I have been asked to evaluate him further. The patient does have a lot of gagging, nausea, and whenever he tries to swallow solids or liquids sometimes they go down and sometimes they do not. He states that it is easier for things go down on the right side of the throat and then on the left side. He feels weak in general. Denies any abdominal pain, frequent heartburns, diarrhea, constipation, or GI bleeding.

PAST MEDICAL HISTORY: Remarkable for history of COPD, oropharyngeal squamous cell carcinoma, apparently was treated successfully a few years ago, but then it returned with involvement of the tongue. He underwent surgery by _ 12 weeks ago with partial resection of his tongue. Also had a PEG tube in the past, which was removed 2-3 years ago.

PERSONAL HISTORY: The patient does smoke, also used to drink a lot of alcohol several years ago. Denies any abuse of illicit drugs.

ALLERGIES: No known drug allergies reported.

CURRENT MEDICATIONS: Reviewed from his MAR.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: The patient feels weak in general. Denies any chest pain. He does have intermittent cough. Also, gets short of breath on exertion. Denies any hemoptysis, dysuria, frequency, hematuria, past history of hepatitis, jaundice, blood transfusions, strokes or seizure disorders, alteration in vision or hearing. He does have some joint pains. Remaining review of 11 systems unremarkable.

PHYSICAL EXAMINATION:
GENERAL: Reveals a frail elderly gentleman in no acute distress.
VITAL SIGNS: Temperature 36.4 degrees centigrade, pulse 76, respirations 16, blood pressure 124/67.
HEENT: Reveals pale and dry mucous membrane without any jaundice or lymphadenopathy. Pupils are round and reactive.
NECK: Supple.
LUNGS: Hyperinflated with decreased breath sounds at both bases.
CARDIAC: Reveals normal heart sounds without any murmurs or gallops.
ABDOMEN: Soft, nontender with no appreciable organomegaly, masses or hernias. Bowel sounds are present.

RECTAL: Deferred.
EXTREMITIES: There is no clubbing, cyanosis or edema of the extremities.
NEUROLOGIC: The patient is alert and oriented with no gross focal neurological deficits.

LABORATORY STUDIES: Revealed white count of 8200, hemoglobin of 11.1, hematocrit of 34.4, platelet count 299,000. BUN 27, creatinine 1.1.

IMPRESSION: A 71-year-old patient with history of recurrent oropharyngeal carcinoma has developed dysphagia, weight loss, dehydration, and could have underlying transfer dysphagia or even esophageal stricture.

PLAN: I discussed the benefits and risks of EGD with PEG tube placement and all indicated procedures including but not limited to the complications of bleeding, perforation, infection, cardio and respiratory complications including death with patient and his wife and daughter. They gave their informed consent and we will plan PEG tube placement later when anesthesia is available for conscious sedation due to intake of narcotics. For now, we will place him on full liquid diet, check his PT, PTT. Also, start him on Pepcid.

Thank you very much for allowing me to participate in the care of who I will follow with you during his stay in the hospital from gastroenterologic point of view.

OPERATIVE REPORT

DATE OF OPERATION:

ATTENDING PHYSICIAN:

PATIENT'S LOCATION:

PROCEDURE: PEG tube placement.

INDICATION:
1. Dysphagia.
2. Weight loss.

HISTORY OF PRESENT ILLNESS: This is a 71-year-old patient with history of recurrent oropharyngeal cancer and the patient is having dysphagia and has lost profound weight and was admitted with dehydration and is undergoing upper GI endoscopy for placement of PEG tube. The benefits and risks including but not limited to bleeding, perforation, infection, cardio and respiratory complications including death along with management of these complications and alternatives discussed in detail. The patient gives his informed consent and in view of history of intake of narcotics, it was felt best to use anesthesia for conscious sedation.

DESCRIPTION OF PROCEDURE: The patient was brought to the endoscopy area, placed in supine position. Conscious sedation was administered by . The lubricated upper video Olympus upper GI endoscope was introduced into esophagus and was advanced under direct vision through gastroesophageal junction, stomach and pylorus into the second portion of duodenum. The mucosa was carefully examined on slow introduction of the scope. Mild erythema was present distal 2 cm of the esophagus. Mild patchy erythema was also present in gastric antrum. A small pouch of hiatal hernia was also identified on retroflexion of the scope in the stomach. The remaining mucosa of upper GI tract appeared unremarkable. The pylorus was patent. At this point, the endoscope was withdrawn into the stomach. The stomach was inflated with air and the light of the scope was transilluminated in the left upper abdomen where a finger indentation could be seen clearly on the anterior gastric wall. This area was cleaned with Betadine and infiltrated with 5 cc of 1% lidocaine after applying sterile drapes. A trocar was introduced and seemed to be coming to the anterior gastric wall into the gastric lumen. The needle was removed and a guidewire was introduced and grasped with the help of a snare and brought out along with the scope. A 20-French PEG tube was tied to the guidewire and placed by pull technique after making a small incision at the site of anterior trocar on anterior abdominal wall. External bumper was applied and located between 2 and 3 cm. The patient tolerated the procedure well with no immediate complications and will be followed in the recovery area.

IMPRESSION:
1. Uneventful placement of PEG tube.
2. Gastritis, esophagitis, small hiatal hernia.

PLAN: I have placed post-PEG orders on the chart. We will continue on Protonix and start using the PEG tube in the morning if stable.